Government of Saskatchewan

Statistical Supplement to the Annual Report for the Year Ending March 31, 1989

Saskatchewan Health

Prescription Drug Services

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Prescription Drug Services

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Prescription Drug Services

Objectives

The Prescription Drug Plan was established to:

1. Reduce the direct cost of prescription drugs to Saskatchewan residents.
2. Provide coverage to Saskatchewan residents for quality pharmaceutical products of proven therapeutic effectiveness.
3. Reduce the cost of drug materials by encouraging effective price competition and quantity discounts.
4. Encourage the rational use of prescription drugs through research, consultation with professional associations, and educational programs directed at physicians, pharmacists and the general public.

The Plan is administered by the Prescription Drug Services Branch of Saskatchewan Health.

History

1. The Prescription Drug Plan began providing benefits on September 1, 1975.
2. In addition to drugs listed in the formulary, certain other drugs are covered if specific criteria are met.
3. The Prescription Drug Services Branch is the paying agent for the Medical Services Division (MSD) and Saskatchewan Aids to Independent Living (SAIL). Payment is made to pharmacies for non-formulary prescription drugs that are benefits for specific clients of these agencies.
4. On January 1, 1989 the Branch eliminated patient paper claims by installing Point Of Sale terminals for each pharmacy to submit claims information electronically.
5. On January 1, 1989, the Prescription Drug Services Branch expanded coverage to eligible drugs purchased anywhere in Canada.

Additional Background to the Plan

The Prescription Drug Plan was designed in consultation with physicians, pharmacists and pharmaceutical wholesalers.

Some of the major design criteria are:

1. The consumer will pay a portion of the prescription cost.
2. A drug formulary system will be used. Only drugs proven to be therapeutically effective and made by competent manufacturers will be eligible for coverage.
3. The existing wholesale and pharmacy retail distribution systems will be used.

The enabling legislation for the Prescription Drug Plan, The Prescription Drugs Act, was assented to on May 10, 1974.

The Plan in Brief

All Saskatchewan residents who hold valid Saskatchewan Health Services Cards, except those who have prescription costs paid by another federal or provincial government agency, are eligible to receive benefits of the Prescription Drug Plan.

Drugs eligible for coverage must be prescribed by a licensed physician or dentist and must be listed in the most current edition of the Saskatchewan Formulary.

The range of drugs listed in the Formulary enables physicians to select appropriate courses of therapy for most patients. Drugs are under continual review, and additional drugs may be added to the Formulary.

Consumers exempted from the deductible program pay no more than $3.95 for each prescription for drugs eligible under the Prescription Drug Plan. This level is unchanged since 1984.

Beneficiaries eligible under the deductible program pay the entire prescription cost at the time of purchase. Claims may be submitted to the Prescription Drug Plan for 80% reimbursement of approved costs in excess of the deductible level.

On January 1, 1989 automated systems were implemented to eliminate consumer submission of claims for prescriptions purchased on and after January 1, 1989. With this change beneficiaries pay the entire prescription cost at the time of purchase only up to the deductible level, and 20% of the prescription cost thereafter, for the balance of the calendar year.

The Prescription Drug Services Branch provides personnel and financial support to the Saskatchewan Formulary Committee, the Drug Quality Assessment Committee, and the Joint Committee on Drug Utilization.

Highlights for 1988-89

- Ninety-five percent of Saskatchewan residents were eligible for benefits under the Prescription Drug Plan.
- Between April 1 and December 31, 1988, an average 9.7 prescriptions were dispensed to each active beneficiary exempt from the deductible program. Between January 1 and March 31, 1989, the average was 4.8 prescriptions.
- Between April 1 and December 31, 1988 an average 20.4 prescriptions were dispensed to each family unit under the deductible program. Between January 1 and March 31, 1989, the average was 4.0 prescriptions.
- The Prescription Drug Plan made reimbursements to family units at an average of $262.07 per family during April 1 to December 31, 1988.
- The Prescription Drug Plan paid an average share of 63.6% of the total prescription costs under the deductible program.
- There were 4.7 million prescriptions processed during the fiscal 12 month period.
- Net Prescription Drug Plan payment for formulary drugs and exception status drugs was $59.7 million during the fiscal 12 month period.
- Pharmacies dispensed 54,816 prescriptions for eligible drugs to beneficiaries receiving additional assistance under the Special Drug Benefits Program.
- Pharmacies dispensed 207,295 prescriptions for eligible drugs to beneficiaries in licensed Special-Care Homes who are exempted from the deductible plan, and contribute a per prescription patient share maximum of $3.95.
- 97 new products were added to the Saskatchewan Formulary bringing the total number of drug products listed to 1874.
- Two editions of the Saskatchewan Formulary Bulletin were released during the year. These presented information to physicians and pharmacists about new products added to the Formulary.
- In consultation with the Saskatchewan Pharmaceutical Association, it was agreed to raise the dispensing fee for drugs from $5.50 to $5.75 effective October 1, 1988 and to $6.00 on January 1, 1989.
- Terminally ill patients covered under The Palliative Care Program received 7,560 prescriptions at no charge to the patient. This program was introduced on July 1, 1987.
- The average drug cost in a prescription was $13.72 during April to December 1988 and $13.45 during January to March 1989.
- During the year, the Prescription Drug Plan provided funding support for:
  a) the College of Medicine Roving Professorship Program which brings information on current drug therapy to physicians in smaller communities throughout the province.
  b) the College of Pharmacy Dial Access Drug Information Service, a province wide drug information service for health professionals.
- Controlled release of information from the data base has been used to fulfill a variety of epidemiological and other research project requests.

Organization of the Prescription Drug Services Branch

Administrative Organization

Executive Director

The Executive Director is responsible for the overall management of the Prescription Drug Services Branch. The Executive Director serves as principal contact on matters of policy and procedures with representatives of pharmacy, medicine, drug wholesalers and drug manufacturers, as well as related sectors in other provincial governments and the federal government, and other agencies with health care involvement.

Administration Division

The Administration Division is responsible for: developing and implementing the administrative policies and procedures; maintaining the Drug Plan data base; specification and production of statistical information; and preparation of the Annual Report.

Functions include: budget preparation and forecast monitoring; space, property and supply management; pharmacy audit; processing of revenue accounts and expenditures (excluding pharmacy claims); ensuring families and pharmacies receive payment; processing of manual claims payment; preparation of reports, materials and financial data for year end statements; mail services; other miscellaneous administrative functions.

The Division provides support services to other Branch functions, including personnel matters, team clerical, and space co-ordination.

The Audit Section conducts post-audits of pharmacy claims to ensure compliance with the Pharmacy Proprietor/Province of Saskatchewan Agreement.

Claims Division

The objectives of the Pharmacy Claims Division are to: provide accurate and prompt payment; maintain efficient and cost-effective operation and processing; maintain claims credibility with pharmacists and family beneficiaries.

The Claims Division is responsible for the processing and payment of accounts submitted by participating pharmacies and eligible families. These accounts are submitted via telecommunication, and, in some cases, paper claims.

Computer services necessary for processing data and claims are co-ordinated by this Division and supplied by Westbridge Computer Corporation and Co-operators Data Services Ltd., under contract to Saskatchewan Health.

Processing and payment of pharmacy claims involves the combined efforts of several sections in the Claims Division. The Systems Section provides analysis and detail design for changes to manual and computer processing of claims. This section also has responsibility for systems control measures, implementation and testing.

The Special Claims Section receives, screens, and assesses incoming claims, transfers the information from these claims to magnetic tape to enable computer processing of accounts. Routine assessments and approval of accounts for payment are performed by computer. Each claim is checked against stored information to determine whether it can be approved for payment. Claims which are not approved for payment are rejected for manual review.

The Inquiry and Verification Section manages the pharmacy and consumer information toll-free phone lines. This section also manages the selection of claims for verification by the beneficiary, and follow-up.

The Claims Division is also responsible for communication with pharmacies regarding Prescription Drug Services Branch claims operations. The division issues periodic bulletins to pharmacies and maintains the Pharmacy Manual.

Professional Services Division

The Professional Services Division is responsible for all matters related to the selection, assurance of quality, acquisition and review of use of all drugs eligible under the Prescription Drug Plan. It is also responsible for communications with consumers, prescribers and pharmacists in matters related to informed, responsible drug use.

This division is comprised of three units, the Formulary and Research Unit, the Drug Cost Control Unit, and the Special Benefits Unit.

The functions of the formulary part of the Formulary and Research Unit include: providing support services to the Drug Quality Assessment Committee and the Saskatchewan Formulary Committee in the review of products under consideration for listing in the Formulary; evaluation of drug costs and preparation of use/cost analysis reports; forwarding recommendations of the Saskatchewan Formulary Committee regarding listing of products, and designation of interchangeable status; publishing and distribution of the Saskatchewan Formulary; ongoing surveillance of manufacturers to ensure compliance with acceptable standards of manufacturing practice; and encouraging rational use of drugs by developing and supporting education programs and services for consumers, physicians and pharmacists.

The research part of the Formulary and Research Unit provides support services to the Joint Committee on Drug Utilization. Activities include research into the use of drugs, comparison of Saskatchewan data with reports of studies in other areas, and preparation of background information for review by the Committee.

This Unit also initiates, directs, and coordinates research projects using Prescription Drug Plan claims data. These projects include in-house drug-use studies and collaborative research projects with outside agencies. The Unit administers the Branch policy and program for release of information, providing assurance that all requirements for confidentiality are met.

This Unit is also responsible for the provision of advisory or consultative services to Saskatchewan Health and outside agencies in matters related to drug use and/or pharmacy services.

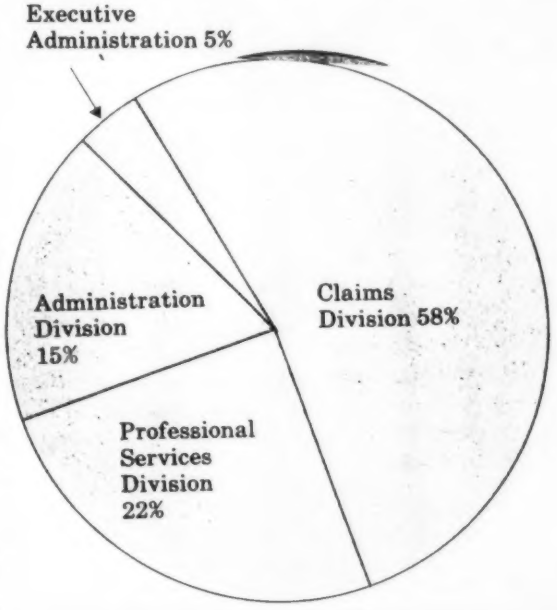
The Drug Cost Control Unit is responsible for ensuring that pharmacies have available to them a continuous supply of quality drugs at reasonable prices; arranging for the acquisition and distribution of drug products listed in the Saskatchewan Formulary by tendering of Standing Offer Contracts for commonly used products and establishing Maximum Allowable Costs in other cases.

The Special Benefits Unit reviews requests from physicians and evaluates and authorizes special categories of drug coverage (for example, Exception Drug Status, Saskatchewan Assistance Plan Two coverage, Palliative Care) when appropriate.

This Unit is also responsible for administering the Special Drug Cost Coverage program by receiving applications from beneficiaries, reviewing and costing the applications, and communicating recommendations of the Drug Benefits Review Panel.

Administrative Disbursements

Figure 1. Administrative Disbursements



The total administrative costs for the fiscal year are separated by Division in Figure 1. The percent allocated to each Division is indicated. The figure illustrates that 20% of these disbursements (approximately .8% of total program costs) are used to administer the program, and that 22% of the disbursements are used to support activities related to assurance of quality and encouragement of the rational use of prescription drugs. For ease of discussion the Divisions and their general functions appear to be distinct. However, the efficiency of the Prescription Drug Plan depends on overall interdependence of the Divisions.

Benefits of the Prescription Drug Plan

With the exception of insulin and diabetes urine testing agents, a prescription from a physician or dentist is required for all drugs eligible under the Drug Plan.

These drugs include all products listed in the Saskatchewan Formulary and certain products for specific individuals, granted through Exception Drug Status authorization.

Formulary Drugs

All drugs listed in the most current edition of the Saskatchewan Formulary are eligible under the Prescription Drug Plan.

Exception Drug Status

Drugs not listed in the Saskatchewan Formulary may be eligible as "exception drugs" if one of the following criteria is met:

1. The drug is ordinarily administered only to hospital in-patients but is being administered outside of a hospital because of unusual circumstances;
2. The drug is not ordinarily prescribed or administered in Saskatchewan, but is being prescribed because it is required in the diagnosis or treatment of an illness, disability, or condition rarely found in Saskatchewan;
3. The drug is infrequently used because formulary preparations are usually effective, but are contraindicated or found to be ineffective due to the clinical condition of the patient;
4. The drug has been deleted from the Formulary but continues to be required by patients previously stabilized on the drug;

Requests for Exception Drug Status must be made by a physician or dentist. Requests may be mailed or telephoned. A 24 hour toll-free prescriber-line is provided by the Prescription Drug Services Branch.

Patients granted such approval are notified by letter, and the claims processing system is updated to accept claims for these drugs via telecommunications.

Patients are responsible to pay their share of costs, just as they would if the drug were listed in the Saskatchewan Formulary.

Products for Diabetics

Persons with diabetes may obtain insulin, urine testing agents, blood glucose testing agents and oral hypoglycemics as benefits under the Prescription Drug Plan, if those products are listed in the Saskatchewan Formulary.

In order to receive coverage, diabetics require a prescription for blood glucose testing agents and oral hypoglycemics, but not for insulin or urine testing agents.

A reduced charge of $1.00 is applied to each package of insulin or urine testing agent obtained. A charge of 20% of the total prescription cost is applied to the purchase of each blood testing agent. These charges are maximums, regardless of level of deductible credits achieved.

Over-The-Counter-Products

Over-the-counter (OTC) products are generally not included as benefits of the Prescription Drug Plan.

Special Drugs

The Prescription Drug Plan provides coverage for the full cost, paid directly to the pharmacy, of certain rarely used drugs which are extremely expensive. Examples include Cyclosporin (used to prevent rejection following organ transplant) and AZT (used to treat A.I.D.S patients). In these cases, no charges are made to the patient.

The Saskatchewan Formulary

The Prescription Drug Services Branch prepares and maintains the Saskatchewan Formulary. The Formulary serves as the list of products eligible under the Prescription Drug Plan and as the Interchangeable Drug Index (IDI). Only those products meeting standards for high quality and relative therapeutic effectiveness are considered for listing.

Drugs listed in the Formulary are under continual review and additions and deletions are recommended when necessary. A revised edition of the Formulary is published twice yearly. The Saskatchewan Formulary Committee is the major resource toward compilation of the Formulary.

The unit drug material cost appears in the Formulary for those products where a Standing Offer Contract (tender) (SOC) is awarded. All other products are listed in descending order of manufacturers price quotes, for the smallest commercially available package size.

Saskatchewan Formulary Committee

The Saskatchewan Formulary Committee is appointed by the Minister of Health to provide advice in the compiling and maintaining of the Saskatchewan Formulary.

This Committee also identifies those products which are "interchangeable". Interchangeable products are different brands of the same drug which are equivalent in therapeutic effectiveness and quality.

Part of the Committee's ongoing work is to review new drug products and to re-evaluate listed products based on new information on their use and effects.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Saskatchewan Formulary Committee as at March 31, 1989 were:

Prof. J. L. (Jack) Summers — Chairman
Mrs. E. Bayda — Saskatchewan Registered Nurses' Association
Dr. M. W. Davies — Saskatchewan Medical Association
Dr. D. Eustace — College of Physicians and Surgeons of Saskatchewan
Dr. R. Herman — College of Medicine
Dr. A. J. Remillard — College of Pharmacy
Mr. N. Shevchuk — Saskatchewan Pharmaceutical Association
Dr. R. West — Saskatchewan Health
Mr. M. Wolfe — Saskatchewan Health-Care Association

Drug Quality Assessment Committee

The Drug Quality Assessment Committee is appointed by the Minister of Health to advise the Saskatchewan Formulary Committee. The members of this committee are knowledgeable in the clinical use of drugs, pharmacology, and drug manufacturing.

This Committee reviews drug products based on information and reports obtained from manufacturers and independent consultants, manufacturing documents and published literature. Recommendations regarding the clinical effectiveness and quality of products are then submitted to the Saskatchewan Formulary Committee.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Drug Quality Assessment Committee as at March 31, 1989 were:

Dr. R. Herman — Chairman
Dr. I. Holmes — Internal Medicine
Dr. A. J. Remillard — Clinical Pharmacy
Dr. A. E. Somerville — Internal Medicine
Dr. T. W. Wilson — Clinical Pharmacology
Dr. D. Zuck — Pharmaceutics
Dr. D. K. J. Gorecki — Pharmaceutical Chemistry
Dr. J. Tuchek — Pharmacology
Prof. J. L. (Jack) Summers — Ex-Officio Member

Joint Committee on Drug Utilization

The Joint Committee on Drug Utilization is appointed by the Minister of Health to consider quality of care issues as they pertain to drug use. The Committee's terms of reference are as follows:

1. To identify areas of concern related to drug utilization.
2. To carry out study and analysis related to the concerns identified.
3. To recommend appropriate methods of dealing with concerns related to drug utilization and its impact on the quality of care.

4. To provide information that can be used in educational programs for the public and the health professions.

The Committee may make recommendations to the Minister of Health or to the professional and regulatory bodies represented on the Committee.

The Prescription Drug Services Branch provides resources and staff support to the Committee.

Members of the Joint Committee on Drug Utilization as at March 31, 1989 are:

Dr. J. Blackburn — Chairman, College of Pharmacy
Dr. W. L. Albritton — College of Medicine
Dr. T. A. Wigmore — College of Physicians and Surgeons
Dr. J. D. Coucill — Saskatchewan Medical Association
Ms. V. Schwabe — Saskatchewan Pharmaceutical Association
Ms. H. Durdin — Saskatchewan Registered Nurses' Association
Mr. T. Quinn — Prescription Drug Services Branch

Eligibility for Coverage

Saskatchewan residents registered with Saskatchewan Health are eligible for benefits under the Prescription Drug Plan unless coverage is provided by another federal or provincial government or non-government agency. The Saskatchewan Drug Plan was instituted, not as a replacement program, but as a coverage vehicle for those residents without such other federal or provincial coverage.

Exclusions from Coverage

The following categories of persons are not eligible for Prescription Drug Plan coverage because coverage is provided by other agencies:

1. Registered Indians (federal government responsibility)
2. Department of Veterans Affairs beneficiaries (federal government responsibility)
3. Royal Canadian Mounted Police (dependents are covered by the Prescription Drug Plan)
4. Canadian Forces Personnel (dependents are covered by the Prescription Drug Plan)

Consumer Cost Share

Most consumers pay the full cost of most drugs eligible under the Prescription Drug Plan, and then submit claims for an 80% reimbursement of amounts over a deductible.

The 1989 calendar year deductible is $125.00 for each family unit, except seniors. The deductible is $50.00 for single seniors, and $75.00 for senior families (where any family member is 65 years or older). The deductible levels remained unchanged from 1987.

Certain consumers are exempted from deductibility. These consumers are Special-Care Home Residents, Social Assistance Recipients, and those registered under the Palliative Care Program. Those with high drug cost and approved by the Drug Benefits Review Panel are granted certain privileges to purchase prescriptions upon up-front payment of 20% of the total prescription cost, with waiver of the deductible. Diabetics can purchase Insulin and Urine testing agents by paying $1.00 per package, and can purchase blood glucose testing agents by paying 20% of the prescription cost, regardless of their deductible status.

Beginning January 1, 1989 with introduction of the computerized claims system and network, consumers no longer pay the full cost of the prescription once over the deductible. The on-line computer system informs the pharmacy that the 20% charge is in effect once the deductible has been paid.

Saskatchewan Assistance Plan Beneficiaries

Residents receiving benefits through the Saskatchewan Assistance Plan are entitled to Prescription Drug Plan benefits at a reduced charge, or at no charge depending on their level of coverage. Deductibles are waived.

a. Plan One Coverage

Plan One beneficiaries 18 years or older are entitled to receive insulin, oral hypoglycemics, injectable vitamin B_{12}, allergenic extracts, oral contraceptives and some products used in megavitamin therapy at no charge. These beneficiaries pay a reduced charge, to a maximum of $2.00, for all other Formulary drugs and Exception Drug Status products. Prior to 1984, this charge was $3.95.

Dependents under 18 are entitled to receive all formulary drugs, allergenic extracts, megavitamins and approved Exception Drug Status products at no charge.

b. Plan Two Coverage

Beneficiaries receiving Plan Two coverage are entitled to receive all formulary drugs, allergenic extracts, megavitamins and approved Exception Drug Status products at no charge.

Plan Two coverage is provided to assist Plan One beneficiaries who require several drugs on a regular long-term basis. Eligibility for Plan Two coverage is determined on the basis of a physician's review of medication requirements, and application to the Prescription Drug Services Branch.

c. Plan Three Coverage

Plan Three beneficiaries are entitled to receive all formulary drugs and certain non-formulary drugs at no charge. Non-formulary drugs are covered by the Medical Services Division (M.S.D. also covers the cost of megavitamins and allergenic extracts for Plan One and Plan Two beneficiaries.)

Plan Three beneficiaries are residents receiving supplementary income assistance who live in Special-Care homes licensed under The Housing and Special-Care Homes Act, Approved Homes licensed under The Mental Health Act, and Wards of the province.

S.A.I.L. Beneficiaries

Saskatchewan Aids to Independent Living (S.A.I.L.) pays for all non-formulary disease-related drugs used by Special Beneficiaries nominated by S.A.I.L. Special Beneficiaries include paraplegics, persons with cystic fibrosis or persons with chronic end-stage renal disease.

These beneficiaries are entitled to receive all prescribed formulary drugs and disease-related non-formulary drugs at no charge.

Special-Care Home Residents

For residents of Special Care homes licenced by the Department of Health under the Housing and Special Care Homes Act, the deductible does not apply. These beneficiaries continue to receive eligible prescriptions for a fixed maximum co-payment of $3.95. This level is unchanged from 1984.

Palliative Care Program

For persons registered under the Palliative Care Program of the Prescription Drug Services Branch, the deductible does not apply. Prescriptions for eligible drugs are provided to them at no charge, a benefit first introduced in 1987.

Special Drug Benefits

Through the Drug Benefits Review Panel, a mechanism exists to enable the review of situations where families or individuals may experience difficulty in meeting payment obligations under the Drug Plan. The three member panel is comprised of representatives of the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Pharmaceutical Association, and the Saskatchewan Department of Health. Members are appointed by the Minister of Health.

Based upon review of information provided by applicants, the Panel may recommend and make available additional benefit for eligible drugs.

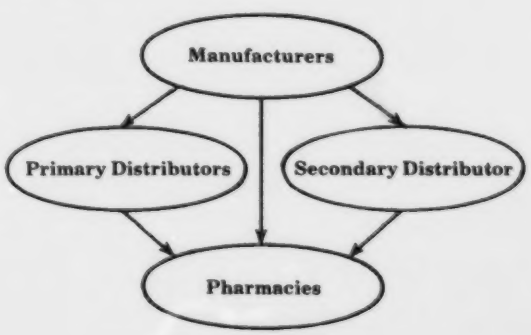
Paying Agency

The Prescription Drug Services Branch functions as a paying agency for M.S.D. and S.A.I.L. for those additional benefits provided to Saskatchewan Assistance Plan beneficiaries and S.A.I.L. Special Beneficiaries.

The appropriate costs are subsequently recovered from M.S.D. and S.A.I.L. by the Prescription Drug Services Branch.

Drug Acquisition and Distribution Network

A continual supply of quality drugs at competitive prices is ensured using the following distribution network:



Distributors purchase drug products from manufacturers and sell them to pharmacies. Pharmacies may also purchase directly from the manufacturer.

As of March 31, 1989, there were four (4) distributors serving the province, three primary and one secondary.

Pricing Formulary Products

In order to ensure price stability for the six month effective Formulary period, the Prescription Drug Services Branch requires drug manufacturers to provide guaranteed maximum prices for the period. The Formulary periods are from January 1 to June 30 and July 1 to December 31 of each year. The prices constitute the maximum the Prescription Drug Plan will consider for those products during the effective Formulary period. Where products are purchased at less than the maximum, the lower price will apply.

Standing Offer Contracts (S.O.C.) are obtained on certain high volume products.

An S.O.C. is a tendered contract between a manufacturer and the Prescription Drug Services Branch to supply specific drug products to approved distributors at a contracted price, and for the specified six month period.

The S.O.C. may not always go to the lowest bidder. Other factors, including an allowance to the previous contract holder, ability to meet supply and distribution commitments, and research and development allowances are also considered.

Once an S.O.C. has been granted, the Prescription Drug Plan will only pay for the S.O.C. drug in an interchangeable category unless the prescriber has specified "no-substitution" of the brand prescribed.

Participating Pharmacies

All pharmacies providing benefit services of the Prescription Drug Plan must sign an Agreement with Saskatchewan Health, and must be located in Saskatchewan.

At March 31, 1989, there were 335 pharmacies delivering Prescription Drug Plan covered services.

Pharmacy Reimbursements

According to the July 1987 — June 1988 Agreement between Saskatchewan Health and pharmacy Proprietors, the pharmacy receives its acquisition cost of drug material, along with a mark-up plus a dispensing fee for each prescription.

The maximum dispensing fee in effect on April 1, 1988 was $5.50. The maximum mark-up allowance is calculated on the drug cost in the prescription as follows: 30% for drug cost up to $4.99, 15% for drug cost between $5.00 and $12.49, and 7% for drug cost of $12.50 and over.

For insulin and urine testing agents, the Prescription Drug Plan pays the pharmacy the cost of the drug material, plus a percentage markup (33 1/3% for insulin, 50% for urine testing agents), less a maximum consumer charge of $1.00.

The maximum dispensing fee was increased on October 1, 1988 to $5.75 and on January 1, 1989 to $6.00. The maximum mark-up allowance calculated on the drug cost in the prescription was increased on October 1, 1988 as follows: 30% for drug cost up to $5.49, 15% for drug cost between $5.50 and $13.74, and 8% for drug cost of $13.75 and over.

Consumers pay the pharmacy for the full cost of the prescription, and then submit claims to the Drug Plan for an 80% reimbursement of amounts over a deductible. This was changed on January 1, 1989 to consumers paying only 20% once their deductible is reached in each calendar year. Consumers therefore are no longer required to submit claims for eligible drug benefits when the drugs are purchased in Saskatchewan.

Consumers exempted from the deductible program continue to pay a maximum of $3.95 as their portion of the total prescription cost. The Pharmacy, for these consumers, continued as in the past to submit claims to the Prescription Drug Services Branch to recover the balance of the costs of the prescription.

Between April 1, 1988 and March 31, 1989, the Prescription Drug Plan paid a total of $59.7 million for Formulary and Exception Status Drug prescriptions.

Prescription Quantities

The Prescription Drug Plan does not limit the quantities of drugs allowed by a prescription. Physicians determine the course and duration of treatment for their patients, limited only by regulations governing the practice of pharmacy.

The Prescription Drug Plan, however, can limit the maximum quantity for which it will pay benefits at any one time. In addition, the pharmacist is entitled to charge a fee for each 34 day supply (or lesser) for most drugs listed in the Formulary.

Product Interchangeability

The Saskatchewan Formulary Committee has identified approximately 300 interchangeable drug groups. Interchangeable products are different brands of the same drug with the same strength and dosage form, that are equivalent in therapeutic effectiveness and quality.

When a prescription is filled for a drug in an interchangeable category, payment is based on the lowest-priced product in that category. For example, if an interchangeable group contains the following brands at the unit prices shown:

Brand 1	$0.0180
Brand 2	0.0190
Brand 3	0.0235
Brand 4	0.0235
Brand 5	0.0252
Brand 6	0.0410

and the physician prescribes any brand in this category, the pharmacist will be reimbursed for the drug dispensed to a maximum of 1.8¢ per unit for those claims submitted to the Drug Plan. If, however, Brand 1 has a Standing Offer Contract, the Prescription Drug Plan will not reimburse the pharmacy unless that brand was dispensed. If a prescription is ordered for any brand other than the low-cost brand listed, and is supported by a "no-substitution" order from the prescriber, reimbursement will be based on the costs of the brand so ordered.

Claims Processing

The Prescription Drug Services Branch provides automated mechanisms and specially designed forms for the purpose of submitting accounts (claims).

All claims are computer or manually checked to ensure completeness, accuracy, and adherence to drug eligibility, price criteria, and patient eligibility.

Beginning January 1, 1989 pharmacies and consumers no longer submit paper claim forms for their accounts. An on-line computer network was installed so that prescription information is transmitted to a central computer and adjudicated. Information regarding cost responsibility is then transmitted back to the pharmacy, outlining the consumer portion of cost that the pharmacy collects, as well as the balance of cost that will be paid to the pharmacy by the Drug Plan.

In the fiscal year ending March 31, 1989, 4.7 million* prescriptions were processed for formulary and exception status drugs.

Data Base Information

The Prescription Drug Services Branch has established policies and guidelines governing access to and use of data base information. These policies and guidelines are necessary to protect the confidentiality of patient information.

All requests for such information must be in writing and addressed to the Executive Director.

* prescriptions filled for patients in the deductible program (after July 1, 1987), but who did not exceed their deductible, are not claimed. These are therefore not recorded by the Drug Plan, explaining the reduced count compared to previous years.

Statistical Synopsis

Prescription Drug Plan Beneficiaries

On July 1, 1987 the Prescription Drug Plan data base changed to a family basis from the previous beneficiary basis because claims processed under the deductible system are by family unit. With this change to family unit, claims information about age, sex, prescriber, pharmacy volume, and manufacturer volumes became non-comparable to previous years. With introduction of the on-line computer network on January 1, 1989, all beneficiary based information will again be retrievable.

Eligible Population (At June 30, 1988)

A total of 986,779 individuals, within 501,127 family units are eligible to receive Prescription Drug Plan benefits.

Of these about 458,400 families are eligible within the deductible program, and 75,000 individuals are exempted from the deductible program, and continue to pay a low fixed co-payment, or no co-payment.

Population Receiving Benefits

Between April and December 1988, 135,373 or 29.5% of eligible families exceeded deductibles and submitted refund claims. In this same period, another 73,992 individual beneficiaries who were exempted from the deductible program received benefits through the Drug Plan. Between January and March 1989, 390,540 individual beneficiaries purchased eligible prescriptions. This represents 39.6% of eligible individuals.

Utilization

Between April and December 1988, each family exceeding the deductible submitted for refund an average of 20.4 prescriptions. In this same period, those individual beneficiaries exempted from the deductible program received an average of 9.7 prescriptions each.

Between January and March 1989, each beneficiary purchasing prescriptions eligible under the Drug Plan received an average of 3.2 prescriptions.

Value of Benefits Received

Between April and December 1988, each family exceeding the deductible received an average refund of $262.07. In this same period, those individual beneficiaries exempted from the deductible program received an average benefit value of $181.42.

Between January and March 1989 each beneficiary purchasing prescriptions covered by the Drug Plan received an average benefit of $9.

Family Unit Type

Between April and December 1988, of the 135,373 family units which exceeded deductibles and submitted refund claims, 32,753 were senior families (at least one member 65 or over), 29,160 were single seniors, 73,331 were non-senior families, and 129 were families where deductibles were adjusted due to family status changes.

In this same period, senior families submitted for refund an average of 26.8 prescriptions, single seniors submitted an average of 19.0 prescriptions, and non-senior families submitted an average of 18.2 prescriptions.

Drugs

During the first three quarters of 1988-89, the Prescription Drug Plan provided coverage for 3.48 million prescriptions for a total payment to pharmacies and individuals of $48.90 million.

During the last quarter of 1988-89, the Prescription Drug Plan provided coverage for 1.25 million prescriptions for a total payment to pharmacies of $10.85 million.

Pharmacies

A total of 335 pharmacy outlets operated under agreement with the Prescription Drug Plan on March 31, 1989. Of these, 69.5% were independent pharmacies, 18.8% were chain outlets, and 6.0% were co-operative.

Prescription Drug Plan Payments

Statistical Tables		
Payments to Pharmacies (on behalf of families)		
April 1988 - December 1988		
Drug Material Acquisition Cost	$10,108,730	
Mark-up	969,885	
Dispensing Fee Subsidy	2,344,762	
Sub-total April - December 1988		$13,423,377
January 1989 - March 1989		
Drug Material Acquisition Cost	$3,332,463	
Mark-up	352,915	
Dispensing Fee Subsidy	747,397	
Sub-total January 1989 - March 1989		$ 4,432,775
Total Payments to Pharmacies on behalf of families exempt from deductible		$17,856,152
Payments to or on behalf of Families (deductible program)		
Total Refunds to Families April 1988 - December 1988 (Table II)		$35,476,868
Total Payments to Pharmacies on behalf of Families January 1989 - March 1989 (Table II)		6,415,528
Total Prescription Drug Plan Payments[1]		$59,748,548
Manual Adjustments[2]		62,754
Net Payments		$59,811,302

Financial Statements

Reimbursements to Pharmacies	
Drug Material Cost[3]	$13,443,024
Special Status Drugs[4]	1,365,032
Dispensing Fee Subsidies[5]	3,044,825
Claims Deductible Plan[6]	6,415,528
Net Payment to Pharmacies	$24,263,188
Reimbursements to Families[7]	35,542,893
	$59,811,302

[1] Payments to Pharmacies during April 1988 — March 1989 and direct to families refer to formulary drugs and exception status drugs. All Statistical Tables do not reflect manual adjustment expenditures.

[2] Manual adjustments include year-end adjustments made in accordance with accounting policies and other adjustments.

[3] See Statement of Revenue, Expenditure and Fund Balance page 24.

[4] Refers to Exception Status Drugs; See Statement of Revenue, Expenditure and Fund Balance page 24.

[5] Refers to dispensing fee subsidies paid by the Prescription Drug Plan. See Statement of Revenue, Expenditure and Fund Balance page 24.

[6] Refers to prescriptions purchased between January 1, 1990 and March 31, 1990 where the beneficiary paid the full cost up to the Deductible and then paid 20% of the cost over the deductible. See Statement of Revenue, Expenditure and Fund Balance page 24.

[7] Refers to prescriptions purchased prior to January 1, 1990 where the beneficiary paid the full cost and sent the receipts to the Drug Plan for refund of 80% over the deductible. See Statement of Revenue, Expenditure and Fund Balance page 24.

Table II

Prescription Drug Plan Payments to or on behalf of Families Under Deductible Program

	1988 Prescriptions	1989 Prescriptions	Total
Payments to or on behalf of Families			
Drug Material Acquisition Cost	$37,669,781	$13,446,268	$51,116,049
Mark-up	3,733,337	1,488,679	5,222,016
Dispensing Fees	14,374,460	5,801,455	20,175,915
Total Approved Prescription Cost	55,777,578	20,736,402	76,513,980
Less: Deductible Credits	11,431,489	12,716,993	24,148,482
	44,346,089	8,019,409	52,365,498
Less Family Co-Payment 20%	8,869,221	1,603,881	10,473,102
Total Prescription Drug Plan Payments to or on behalf of Families	$35,476,868	$6,415,528	$41,892,396

Table III

Prescription Drug Utilization by Family Unit Type Under Deductible Program

Family Unit Type	Number of Family Units	Number of Prescriptions	Drug Material Cost	Approved Prescription Cost	Net Family Payments[1]	Drug Plan Payments
1988 Prescriptions[2]						
Under 65 Family	73,331	1,331,457	$20,837,163	$27,752,604	$12,293,520	$15,459,084
65 and over Single	32,753	878,074	13,078,855	17,603,925	5,010,525	12,593,400
65 and over	29,160	554,868	7,462,065	10,388,770	2,989,671	7,399,099
Others[3]	129	1,385	25,035	32,279	6,994	25,285
1989 Prescriptions[4]						
Under 65 Family	183,283	592,027	$8,345,374	$11,690,104	$9,652,063	$2,038,041
65 and over Single	37,536	260,738	4,145,924	5,614,396	2,907,952	2,706,444
65 and over	33,502	172,002	2,443,649	3,431,902	1,760,859	1,671,043

[1] Net Family Payments is the net cost to a family being the total of the deductible and the 20% not reimbursed by the Drug Plan.

[2] Prescriptions processed from claims received from families that incurred prescription costs greater than the deductible.

[3] Families submitting claims where, due to adjustment in family structures, a deductible was waived.

[4] Prescriptions processed from claims received on-line from pharmacies for all families even though the family cost may be less than the deductible.

Prescription Cost to Families Under Deductible Program

Cost to Family Unit	Number of Family Units	Number of Prescriptions[4]	Drug Material Cost[5]	Approved Prescription Cost	Net Family Payments[1]	Drug Plan Payments
1988 Prescriptions[2]						
$ 00.00 - 25.00	1,415	4,504	$ 38,943	$ 62,565	$ 21,867	$ 40,698
25.01 - 50.00	2,846	21,208	209,443	320,782	109,931	210,851
50.01 - 75.00	11,546	117,198	1,037,226	1,649,217	727,238	921,979
75.01 - 100.00	15,215	216,608	2,187,674	3,315,228	1,330,534	1,984,694
100.01 - 125.00	13,295	252,102	2,927,833	4,238,049	1,490,857	2,747,192
125.01 - 150.00	35,016	520,281	6,328,929	9,025,589	4,802,506	4,223,083
150.01 - 175.00	19,861	417,325	5,637,707	7,802,252	3,200,631	4,601,621
175.01 - 200.00	12,099	312,023	4,827,987	6,446,782	2,259,531	4,187,251
200.01 - 225.00	8,251	247,218	4,165,304	5,445,184	1,745,654	3,699,530
225.01 - 250.00	5,150	174,131	3,218,121	4,119,285	1,218,365	2,900,920
250.01 - 275.00	3,454	131,323	2,565,118	3,250,571	903,431	2,347,140
275.01 - 300.00	2,302	94,355	1,988,607	2,481,617	659,732	1,821,885
300.01 - 400.00	3,757	181,399	4,176,150	5,126,225	1,267,725	3,858,500
400.01 - 500.00	825	49,479	1,307,091	1,565,670	359,461	1,206,209
500.01 and over	341	26,630	786,985	928,562	203,247	725,315
All	135,373	2,765,784	$41,403,118	$55,777,578	$20,300,710	$35,476,868
1989 Prescriptions[3]						
$ 00.00 - 25.00	75,869	100,774	$ 510,480	$ 1,075,040	$ 1,074,200	$ 840
25.01 - 50.00	58,380	141,396	1,276,585	2,073,763	2,071,487	2,276
50.01 - 75.00	47,790	194,913	2,328,523	3,439,548	2,880,326	559,222
75.01 - 100.00	30,400	189,975	2,669,943	3,744,491	2,613,350	1,131,141
100.01 - 125.00	14,890	122,356	2,052,052	2,743,609	1,655,028	1,088,581
125.01 - 150.00	18,064	151,733	2,858,002	3,716,822	2,432,180	1,284,642
150.01 - 175.00	5,502	66,641	1,537,462	1,915,941	883,177	1,032,764
175.01 - 200.00	1,941	29,009	764,629	930,073	360,170	569,903
200.01 - 225.00	768	13,194	395,391	470,540	161,730	308,810
225.01 - 250.00	352	6,615	220,516	258,413	83,006	175,407
250.01 - 275.00	176	3,938	130,763	153,343	45,863	107,480
275.01 - 300.00	85	1,845	71,274	81,904	24,274	57,630
300.01 - 400.00	91	2,012	97,815	109,243	30,128	79,115
400.01 - 500.00	10	252	14,757	16,268	4,214	12,054
500.01 and over	3	114	6,755	7,404	1,741	5,663
All	254,321	1,024,767	$14,934,947	$20,736,402	$14,320,874	$ 6,415,528

[1] Net Family Payments is the net cost to a family being the total of the deductible and the 20% family co-payment for prescription cost over the deductible.

[2] Drug Plan Payments for 1988 prescriptions are refunds to families.

[3] Drug Plan Payments for 1989 prescriptions are payments to pharmacies.

[4] Refers to formulary drugs and exception status drugs.

[5] Includes mark-up on drug acquisition cost.

Prescription Cost to Families Exempt from Deductible Program

Cost to Family (Consumer Cost)	Number of Active Families	Number of Prescriptions [1]	Drug Material Cost [5]	Approved Prescription Cost	Net Family Payments [3]	Drug Plan Payment to Pharmacy
April-December 1988						
$ 0.01 - 10.00	30,839	269,431	$ 3,945,974	$ 5,389,774	$ 76,608	$ 5,313,167
10.01 - 20.00	6,223	64,391	853,123	1,164,224	94,564	1,069,659
20.01 - 30.00	3,227	46,717	698,188	927,777	81,019	846,758
30.01 - 40.00	2,306	37,436	564,879	754,869	81,107	673,763
40.01 - 50.00	1,448	28,558	441,725	588,584	65,301	523,282
50.01 - 60.00	1,244	26,303	408,821	547,484	68,868	478,616
60.01 - 70.00	859	20,751	326,718	434,998	55,934	379,063
70.01 - 80.00	899	22,036	359,024	476,880	67,162	409,719
80.01 - 90.00	534	14,943	231,297	310,683	45,367	265,316
90.01 - 100.00	594	16,924	252,542	343,928	56,463	287,465
100.01 - 150.00	1,769	58,558	877,176	1,195,635	216,600	979,035
150.01 - 200.00	954	39,950	623,077	843,647	163,267	680,380
200.01 - 300.00	789	42,074	721,523	954,370	189,196	765,174
300.01 - 400.00	257	16,410	373,990	465,000	87,783	377,217
400.01 - 500.00	88	5,822	164,312	196,340	39,073	157,267
500.01 and over	77	6,031	236,246	269,579	52,083	217,496
	52,107	716,335	$11,078,615	$14,863,772	$1,440,395	$13,423,377
January-March 1989						
$ 0	10,383	61,646	$ 1,068,532	$ 1,425,100	$ 0	$ 1,425,100
0.01 - 25.00	21,538	88,214	1,290,798	1,756,946	172,503	1,584,443
25.01 - 50.00	3,384	32,992	528,948	715,641	119,833	595,808
50.01 - 75.00	1,318	19,110	307,033	416,359	79,043	337,316
75.01 - 100.00	532	9,874	182,848	239,129	45,325	193,804
100.01 - 125.00	211	4,288	99,118	122,860	23,354	99,506
125.01 - 150.00	112	2,336	68,420	81,603	15,365	66,238
150.01 - 175.00	62	1,412	44,329	52,541	10,071	42,470
175.01 - 200.00	44	1,042	35,926	41,578	8,200	33,378
200.01 - 225.00	26	727	24,187	28,283	5,549	22,734
225.01 - 250.00	11	289	11,409	13,062	2,590	10,472
250.01 - 275.00	9	247	10,363	11,764	2,354	9,410
275.01 - 300.00	4	117	5,112	5,814	1,163	4,651
300.01 - 400.00	4	171	6,319	7,039	1,395	5,644
400.01 - 500.00	1	36	2,036	2,252	451	1,801
	37,639	222,501	$3,685,378	$4,919,971	$487,196	$4,432,775

[1] Refers to formulary and exception status drugs.

[2] Includes mark-up on drug acquisition cost.

[3] Refers to the prescription charge or the 20% paid by the consumer on drugs exempt from deductible.

Prescription Drug Utilization by Age and Sex for Consumers Exempt from Deductible Program

Age of Consumer	Active Beneficiaries	Number of Prescriptions	Drug Material Cost	Dispensing Fee	Drug Plan Payment to Pharmacy
April - December 1988 (as submitted by pharmacies on behalf of all deductible exempt beneficiaries)					
Male					
0 - 4	3,948	14,157	$ 126,341	$ 78,149	$ 201,584
5 - 14	3,360	13,355	260,225	70,382	312,408
15 - 24	3,683	20,665	315,048	104,512	398,557
25 - 34	3,544	30,139	548,112	153,631	662,014
35 - 44	2,761	30,791	578,582	158,517	691,062
45 - 54	2,487	30,923	603,489	159,099	710,387
55 - 64	3,306	47,030	864,839	241,122	1,017,025
65 - 74	2,596	35,904	674,516	179,717	757,334
75 - 84	2,291	39,616	578,500	208,453	674,114
85 and over	1,529	31,505	356,829	173,478	440,612
Male Total	29,505	294,085	$ 4,906,481	$ 1,527,060	$ 5,865,097
Female					
0 - 4	3,623	13,128	$ 103,919	$ 69,011	$ 171,175
5 - 14	3,580	12,841	209,980	70,371	268,258
15 - 24	6,942	34,553	523,303	184,726	667,505
25 - 34	5,805	39,575	680,307	213,143	825,388
35 - 44	3,289	34,951	558,306	185,776	685,892
45 - 54	2,534	34,954	584,316	181,690	708,449
55 - 64	3,034	47,589	836,521	248,012	991,354
65 - 74	2,757	46,198	782,638	237,692	902,497
75 - 84	3,562	72,816	991,960	392,435	1,181,048
85 and over	3,701	85,645	900,884	475,241	1,156,714
Female Total	38,827	422,250	$ 6,172,134	$2,258,097	$ 7,558,280
Both Sexes					
0 - 4	7,571	27,285	$ 230,260	$ 147,160	$ 372,759
5 - 14	6,940	26,196	470,205	140,753	580,666
15 - 24	10,625	55,218	838,351	289,238	1,066,062
25 - 34	9,349	69,714	1,228,419	366,774	1,487,402
35 - 44	6,050	65,742	1,136,888	344,293	1,376,954
45 - 54	5,021	65,877	1,187,805	340,789	1,418,836
55 - 64	6,340	94,619	1,701,360	489,134	2,008,379
65 - 74	5,353	82,102	1,457,154	417,409	1,659,831
75 - 84	5,853	112,432	1,570,460	600,888	1,855,162
85 and over	5,230	117,150	1,257,713	648,719	1,597,326
Grand Total	68,332	716,335[1]	$11,078,615[2]	$3,785,157[3]	13,423,377[4]

[1] Refers to formulary and exception status drugs.

[2] Includes mark-up on drug acquisition cost.

[3] The Dispensing fee charged by pharmacy for the prescriptions dispensed.

[4] Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee, less prescriptions charges paid by the consumer to the pharmacy.

Prescription Drug Utilization by Age and Sex of Consumer (Payments to Pharmacies)

Age of Consumer	Active Beneficiaries	Number of Prescriptions	Drug Material Cost	Dispensing Fee	Drug Plan Payment to Pharmacy
January- March 1989 (as billed by pharmacies for all prescriptions to all beneficiaries)					
Male					
0 - 4	16,500	30,257	$ 246,860	$ 172,673	$ 88,867
5 - 14	16,960	28,220	349,063	161,024	149,114
15 - 24	15,870	30,610	418,505	172,876	207,553
25 - 34	20,106	43,684	630,464	246,890	313,292
35 - 44	18,514	47,429	778,689	266,987	395,745
45 - 54	16,779	54,388	981,195	305,393	489,823
55 - 64	20,816	82,789	1,552,945	461,754	875,931
65 - 74	20,072	95,240	1,654,170	531,761	1,181,184
75 - 84	12,837	69,347	1,069,238	392,671	828,686
85 and over	3,667	22,009	273,521	127,326	252,120
Male Total	162,121	503,973	$ 7,954,650	$2,839,355	$ 4,782,315
Female					
0 - 4	14,984	25,880	$ 194,169	$ 148,145	$ 71,249
5 - 14	17,363	27,879	297,141	158,900	121,087
15 - 24	33,563	67,534	1,035,655	380,133	279,163
25 - 34	37,745	83,487	1,273,796	469,517	412,082
35 - 44	24,279	65,707	920,596	367,696	404,942
45 - 54	21,665	74,895	1,100,815	419,301	525,445
55 - 64	25,320	104,770	1,638,748	583,694	942,693
65 - 74	27,297	134,801	2,100,654	758,364	1,508,939
75 - 84	19,332	112,097	1,571,417	640,919	1,257,241
85 and over	6,871	46,245	532,684	270,023	543,147
Female Total	228,419	743,295	$10,665,675	$4,196,692	$6,065,988
Both Sexes					
0 - 4	31,484	56,137	$ 441,029	$ 320,818	$ 160,116
5 - 14	34,323	56,099	646,204	319,924	270,201
15 - 24	49,433	98,144	1,454,160	553,009	486,716
25 - 34	57,851	127,171	1,904,260	716,407	725,374
35 - 44	42,793	113,136	1,699,285	634,683	800,687
45 - 54	38,444	129,283	2,082,010	724,694	1,015,268
55 - 64	46,136	187,559	3,191,693	1,045,448	1,818,624
65 - 74	47,369	230,041	3,754,824	1,290,125	2,690,123
75 - 84	32,169	181,444	2,640,655	1,033,590	2,085,927
85 and over	10,538	68,254	806,205	397,349	795,267
Grand Total	390,540	1,247,268[1]	$18,620,325[2]	$7,036,047[3]	$10,848,303[4]

[1] Refers to formulary and exception status drugs.

[2] Includes mark-up on drug acquisition cost.

[3] The Dispensing fee charged by pharmacy for the prescriptions dispensed.

[4] Drug Plan Payment is the total of the Drug Material Cost and Dispensing fee, less prescriptions charges paid by the consumer to the pharmacy.

Prescription Drug Use by Type of Beneficiary

Type of Beneficiary[1]	Active Beneficiaries[2]	Number of Prescriptions[3]	Total Drug Plan Payment
April - December 1988			
Standard Beneficiaries[4]	14,513	127,559	$ 2,274,250
Saskatchewan Assistance Plan Recipients			
— Prescription Charge Subsidized (Plan One)	20,090	138,154	2,439,715
— Prescription Charge Fully Covered			
Special Drugs for Plan One	4,856	21,833	462,730
Dependents of Plan One to Age 18	13,801	43,690	629,675
Plans Two and Three	10,076	156,391	2,724,799
Special Beneficiaries			
— Paraplegics	794	14,234	341,188
— Cystic Fibrosis	110	1,560	68,978
Chronic Renal Disease	309	10,182	507,069
Nursing Home Residents	7,200	156,889	2,192,509
Special Drug Coverage	1,608	39,552	1,069,697
Palliative Care	466	5,490	239,492
Special Drugs	169	801	473,275
Total	73,992	716,335	13,423,377
January - March 1989			
Standard Beneficiaries[4]	9,007	38,785	$ 781,591
Saskatchewan Assistance Plan Recipients			
— Prescription Charge Subsidized (Plan One)	12,239	43,317	801,553
— Prescription Charge Fully Covered			
Special Drugs for Plan One	2,741	5,647	131,914
Dependents of Plan One to Age 18	6,875	13,017	199,792
Plans Two and Three	6,493	46,532	869,438
Special Beneficiaries			
— Paraplegics	709	4,035	105,712
— Cystic Fibrosis	91	416	11,289
— Chronic Renal Disease	262	2,779	166,163
— Other	1	1	72
Nursing Home Residents	5,891	50,406	747,562
Special Drug Coverage	2,134	15,264	387,491
Palliative Care	263	2,070	83,881
Special Drugs	122	232	146,317
Total	46,828	222,501	$ 4,432,775

[1] Beneficiaries that obtained the prescription exempt from the deductible.

[2] Total does not equal this column because a beneficiary may be covered in more than one category during the fiscal year.

[3] Refers to formulary and exception status drugs.

[4] Beneficiaries for whom insulin, testing agents, and provisional special drug coverage claims were paid.

Prescriptions by Pharmacologic — Therapeutic Classification

Pharmacologic — Therapeutic Classification[1]		Number of Prescriptions[2]	Drug Material Cost[3]	Total Drug Plan Payment
April - December 1988 (as submitted by pharmacies on behalf of deductible exempted beneficiaries)				
8:00	Anti-Infectives	80,278	$ 673,781	$ 1,027,886
12:00	Autonomic Drugs	31,348	535,516	647,436
20:00	Blood Formation and Coagulation	2,860	58,956	66,988
24:00	Cardiovascular Drugs	79,975	1,471,207	1,683,020
28:00	Central Nervous System Drugs	182,824	2,388,074	3,069,579
36:00	Diagnostic Agents	31,698	975,501	937,856
40:00	Electrolytic, Caloric and Water Balance	43,954	183,909	323,949
48:00	Cough Preparations	76	2,599	2,955
52:00	Eye, Ear, Nose and Throat Preparations	17,127	205,366	270,996
56:00	Gastrointestinal Drugs	25,719	704,073	782,890
60:00	Gold Compounds	261	17,550	16,733
64:00	Metal Antiagonists	282	29,087	29,430
68:00	Hormones and Substitutes	149,384	2,021,227	2,522,202
76:00	Oxytocics	24	96	190
84:00	Skin and Mucous Membrane Preparations	29,036	375,065	489,761
86:00	Spasmolytics	9,757	164,399	199,302
88:00	Vitamins	6,114	29,405	51,709
92:00	Unclassified	25,618	1,242,804	1,300,495
Total		716,335	$11,078,615	$13,423,377
January - March 1989 (as submitted by pharmacies for all beneficiaries)				
8:00	Anti-Infectives	230,276	$ 1,769,295	$ 659,117
12:00	Autonomic Drugs	46,188	860,331	540,946
20:00	Blood Formation and Coagulation	5,827	111,124	73,294
24:00	Cardiovascular Drugs	256,948	5,131,239	3,021,279
28:00	Central Nervous System Drugs	261,346	3,478,770	2,237,430
36:00	Diagnostic Agents	10,982	360,074	343,892
40:00	Electrolytic, Caloric and Water Balance	63,308	243,707	287,602
48:00	Cough Preparations	48	1,866	1,737
52:00	Eye, Ear, Nose and Throat Preparations	43,287	585,647	269,749
56:00	Gastrointestinal Drugs	53,865	1,389,846	834,259
60:00	Gold Compounds	669	43,640	27,191
64:00	Metal Antiagonists	646	29,608	18,758
68:00	Hormones and Substitutes	152,376	2,336,927	1,171,874
76:00	Oxytocics	70	307	144
84:00	Skin and Mucous Membrane Preparations	61,680	781,943	311,759
86:00	Spasmolytics	15,143	242,619	167,115
88:00	Vitamins	7,222	42,449	35,851
92:00	Unclassified	37,387	1,210,933	846,306
Total		1,247,268	18,620,325	10,848,303

[1] The drug classification system used is that of the American Society of Hospital Pharmacists.

[2] Refers to formulary drugs and exception status drugs.

[3] Includes Mark-up on drug acquisition cost.

Prescriptions by Pharmacologic — Therapeutic Classification (Deductible Program)

Pharmacologic — Therapeutic Classification[1]		Number of Prescriptions[2]	Drug Material Cost[3]	Approved Prescription Cost
April - December 1988 (as submitted by families once over the deductible)				
8:00	Anti-Infectives	364,817	$ 2,925,267	$ 4,852,492
12:00	Autonomic Drugs	113,832	2,125,747	2,717,579
20:00	Blood Formation and Coagulation	16,695	304,621	391,108
24:00	Cardiovascular Drugs	785,614	14,641,631	18,706,139
28:00	Central Nervous System Drugs	596,449	8,336,901	11,436,945
36:00	Diagnostic Agents	84	2,484	2,925
40:00	Electrolytic, Caloric and Water Balance	169,993	678,278	1,562,363
48:00	Cough Preparations	63	2,592	2,926
52:00	Eye, Ear, Nose and Throat Preparations	98,279	1,417,571	1,927,313
56:00	Gastrointestinal Drugs	103,491	2,714,876	3,251,519
60:00	Gold Compounds	2,054	132,177	142,907
64:00	Metal Antiagonists	2,136	83,817	94,711
68:00	Hormones and Substitutes	251,791	3,559,829	4,860,044
76:00	Oxytocics	72	432	811
84:00	Skin and Mucous Membrane Preparations	104,669	1,368,476	1,912,450
86:00	Spasmolytics	40,976	621,932	834,248
88:00	Vitamins	15,718	99,672	180,717
92:00	Unclassified	99,051	2,386,815	2,900,381
Total		2,765,784	$41,403,118	$55,777,578

[1] The drug classification system used is that of the American Society of Hospital Pharmacists.

[2] Refers to formulary drugs and exception status drugs.

[3] Includes Mark-up on drug acquisition cost.

Pharmacies by Location

Location of Pharmacy	Number of Pharmacies[1]
Single Pharmacy Communities	86
2 — 5 Pharmacy Communities	77
Communities With More Than 5 Pharmacies	
Moose Jaw	11
North Battleford	7
Prince Albert	13
Regina	45
Saskatoon	59
Swift Current	8
Yorkton	8
Dispensing Doctors	14
Border Pharmacies	7
Total	335

[1] Includes all pharmacies operating under agreement with the Prescription Drug Plan on March 31, 1989.

Pharmacies by Type of Ownership

Type of Ownership	Pharmacies[1] Number	Percent
Independent	233	69.5
Chain[2]	63	18.8
Co-operatives	20	6.0
Dispensing Doctor	14	4.2
Hospital Outpatient	5	1.5
Total	335	100.0

[1] Includes all pharmacies operating under agreement with the Prescription Drug Plan on March 31, 1989.
[2] Defined as common ownership of four or more stores.

Statement of Revenue, Expenditure and Fund Balance (Unaudited) — Statement 1

Year Ended March 31

	1989	1988
Operating Revenue:		
Grant — Department of Health	$60,214,025	$59,453,000
Other	4,352	2,619
	$60,218,377	$59,455,619
Operating Expenditure:		
Reimbursements:		
Deductible Exempt		
Drug Material Cost	$13,443,024	$34,707,775
Special Status Drugs	1,365,032	784,165
Dispensing Fee Subsidies	3,044,825	5,304,765
Drug Cost Advances (Recoveries)	78,139	—
Deductible Plan		
Patient Claims	35,542,893	16,587,573
Pharmacy Claims	6,415,528	—
Other	449,910	78,216
	$60,339,351	59,322,378
Surplus (deficit) for the year	(120,974)	133,241
Fund balance, beginning of year	133,241	—
Fund balance, end of year	$ 12,267	$ 133,241